



# Children's Dental Clinic Regina

Pediatric and Orthodontic Dental Clinic

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Dr. Htet Bo Dr. Charles Lekic Dr. Christopher Yue Dr. Alvaro Salles  
Dr. Milos Lekic Dr. Nick Lekic

Date of referral \_\_\_\_\_ Parent/Guardian \_\_\_\_\_  
Name of Patient \_\_\_\_\_ Home Phone # \_\_\_\_\_  
Address \_\_\_\_\_ Email \_\_\_\_\_  
DOB (d/m/y) \_\_\_\_\_ Referring Dentist \_\_\_\_\_  
Mobile Phone # \_\_\_\_\_ Referring Office \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## For Pediatric Dentistry

First Available Pediatric Dentist  Specific Pediatric Dentist \_\_\_\_\_

This is a referral regarding:

Pain/Swelling  General Anaesthetic  Emergency  \_\_\_\_\_

## For orthodontics

First Available Orthodontist  Specific Orthodontist: \_\_\_\_\_

Please evaluate for:

Comprehensive Orthodontic Treatment  Early Treatment/Growth Modification

Comments: \_\_\_\_\_

	Y	N
Please call the parent/guardian to arrange appointment	<input type="checkbox"/>	<input type="checkbox"/>
We are sending the most current radiographs	<input type="checkbox"/>	<input type="checkbox"/>
Please inform us of treatment completed	<input type="checkbox"/>	<input type="checkbox"/>

## Insurance Information

### Primary Insurance

Subscriber Name \_\_\_\_\_  
DOB (d/m/y) \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group/Policy # \_\_\_\_\_  
ID Number \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Secondary Insurance

Subscriber Name \_\_\_\_\_  
DOB (d/m/y) \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group/Policy # \_\_\_\_\_  
ID Number \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Upon completion of treatment please have patient return to our office for recalls  Y  N